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Nursing Home Documentation Recommendations

At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection on services submitted to Healthfirst. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.

Nursing Home Retention Policy

- A nursing home's retention policy covers how long a facility keeps residents' clinical and other records
- CMS mandates a 10-year patient record retention for Medicare managed care programs

Nursing Home Documentation Recommendations
Medical Record • Name, DOB, Medical Record Number • Past Medical History (PMH) • Vital signs, weight sheets, care plans, treatment records • Current Physical reports (including current list of medications) • Current functional status of residents • Responsiveness to treatments • Progress toward goals • The need for continued care in the facility • The results of any preadmission screening conducted by the state • Include Discharge Summary from hospital or other facility for thorough background of PMH • Discharge planning from SNFs needs to be documented from day 1. • Physician/Non-Physician Practitioner (NPP) certification and re-certifications
Date of Service A clear date of service must be displayed on all pages, any records which are missing a date of service are deemed invalid.

Nursing Home Documentation Recommendations (cont.)

- Practitioner and ancillary progress notes
- Medical necessity for Nursing Home
- Activities of Daily Living Logs
- Nurse aide notes
- Treatment Plan
- Consultations

Physical Therapy (PT) / Occupational Therapy (OT) / Speech-Language Pathology (SLP)

- Initial evaluation and re-evaluations
- Plan of care/updates to Plan of Care
- Treatment encounter notes
- Therapy minutes log
- Discharge summary

Signature and Credentials

- Medical record entries must be complete and authenticated by the physician/practitioner who is responsible for ordering, providing, or evaluating the services furnished.
- Acceptable provider authentication comes in the form of handwritten and electronic signatures with credentials.
- Each date of service must be signed in a timely manner along with legible signature, credentials and the date signed.
- As per CMS, stamped signatures are not acceptable; exceptions include providers with proven disabilities.

Documentation Tips

- Write legibly and without spelling errors
- Correct mistakes by drawing a single line through it so it's still legible, write "mistaken entry" next to the original words, signature and date it
- Avoid contradictory documentation
  - i.e. Avoid both CKD Stage 3a and CKD Stage 4

Common Documentation Errors
• Incorrect patient information (Name, DOB, Medical Record Number) • Documenting “history of’ for Dx when the Dx is still active • Documenting Dx using uncertainty terms such as probable, apparently, likely, suspected • Documenting without specificity when capturing Dx • i.e. Major Depressive Disorder • Depression, unspecified (Incorrect) • Major depressive disorder, recurrent, mild (Correct)
Common Coding Errors
• Upcoding (Coding Dx without Supporting Documentation) • Downcoding (Not Coding Dx that has Valid Documentation) • Capturing the incorrect code based on what is documented in the progress note   ○ i.e. Capturing N18.9, chronic kidney disease, unspecified, when the progress note has Chronic Kidney Disease, Stage 3A

References

- CMS RADV Medical Record Reviewer Guidance
- ICD-10-CM Official Coding Guidelines FY2026
- Medical Coding in Nursing Home - AAPC Knowledge Center
- Medicare Documentation Guidelines for Nursing Home | IntelyCare
- ABCs of an Effective Skilled Nursing Note - Proactive LTC Consulting
- CMS – Medical Record Retention

Questions?

Contact us at #Risk_Adjustments_and_clinical_Documentation@healthfirst.org.

For additional documentation and coding guidance, please visit the coding section on HFproviders.org

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